STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155166	B. WING		11/28/2012
NAME OF I	PROVIDER OR SUPPLIE	ER	STREE	T ADDRESS, CITY, STATE, ZIP CODE	•
				VALL ST	
VALPAR	AISO CARE AND	REHABILITATION CENTER	VALF	PARAISO, IN 46383	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
F0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE (	DATE
1 0000					
	This visit was f	or the Investigation of	F0000	The creation and submission	n of
		0112997 and Complaint		this Plan of Correction does	
	IN00114283.			constitute an admission by the	
	11,0011.205.			provider of any conclusion s forth in the statement of	et
	Complaint IN00	0112997-Substantiated.		deficiencies, or of any violati	on of
	•	eficiencies related to the		regulation. This provider	
		cited at F157 and F514		respectfully requests that the	
				2567 Plan of Correction be considered the Letter of Cre	diblo
	Complaint IN0	0114283-Substantiated.		Allegation and requests a po	
	•	eficiencies related to the		survey desk review on or aft	
		cited at F157 and F314.		December 28, 2012.	
	unegations are	oned at 1137 and 1311.			
	Unrelated defic	iency cited			
		ioney enea.			
	Survey dates:				
	November 25-2	28 2012			
	110101111111111111111111111111111111111	, 2012			
	Facility number	r: 000083			
	Provider number				
	AIM number: 1				
	111111110011100111	2002070			
	Survey team:				
	Janet Adams, R	.N			
	, control rading, re				
	Census bed type	e:			
	SNF/NF: 146				
	Total: 146				
	Census payor ty	vpe:			
	Medicare: 20	/ r			
	Medicaid: 114				
	Other: 12				
	Juio1. 12				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000083

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		A. BUILDING  B. WING	COMPLETED  11/28/2012				
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	Total: 146						
	Sample: 14						
		reflect State findings e with 410 IAC 16.2.					
	Quality review cor 2012 by Bev Faulk	mpleted on December 2, tner, RN					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

If continuation sheet Page 2 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155166	B. WING		11/28/2012	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	606 W	ADDRESS, CITY, STATE, ZIP CODE ALL ST IRAISO, IN 46383		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	DROUBERS N. AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0157 SS=D	A facility must im resident; consult physician; and if legal representar member when the resident which the potential for intervention; a si resident's physicistatus (i.e., a defor psychosocial threatening concomplications); a significantly (i.e., existing form of the consequences, conferences, conferen	NE/ROOM, ETC) Immediately inform the with the resident's known, notify the resident's tive or an interested family lere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial lerioration in health, mental, status in either life litions or clinical a need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or sident from the facility as 8.12(a).  also promptly notify the nown, the resident's legal or interested family member change in room or ment as specified in or a change in resident rights or State law or regulations as graph (b)(1) of this section.				
	Based on record facility failed to change in woun residents review	I review and interview, the notify the Physician of a d drainage for 1 of 4 yed for wounds in the esident #D). The facility	F0157	F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately information the resident; consult with the resident's physician; and if known, notify the resident's leg		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

If continuation sheet Page 3 of 30

DENTIFICATION NUMBER: 155166  NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER  VALPARAISO, IN 46383  SIRBET ADDRESS, CITY, STATE ZIP CODE 606 WALL ST 7 VALPARAISO, IN 46383	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER  VALPARAISO, IN 46383  SIRRET ADDRINS, CITY, STATE, ZIP CODE  600 WALL ST VALPARAISO, IN 46383  D PROVIDER OR SUPPLIER  (ACH DEFICIENCY MIST BE PRECIPED BY PELL TAG  RIGULATORY OR ISC DENTIFYING INFORMATION)  Also failed to ensure timely attempts were made to notify the family of a resident's death for 1 of 3 discharged residents reviewed in the sample of 14.  (Resident #G)  1. The closed record for Resident #G was reviewed on 11/26/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, renal failure, adult failure to thrive, esophageal reflux, and high blood pressure. The resident was admitted to the facility on 4/7/12 and discharged to the hospital on 5/9/12. The resident was re-admitted to the facility on 5/16/12 from an inpatient Hospice facility. The resident expired at the facility on 5/19/12.  Review of the resident's Admission information face sheet indicated three was no Funeral Home listed. One of the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,  STREET ADDRINS, CITY, STATE, ZIP CODE 600 WALL ST VAL PARAISO, IN 46383  ID PROVIDER OF CARL PROFICENCIES (SCAT PROFICENCIES OF CARL PROFICENCIES OF CARL PROFICENCIES OF COMPLETION (25)  PROFICENCY MALL ST VAL PARAISO, IN 46383  D PROFICENCIES OF CARL PROFICENCIES OF CARL PROFICENCIES OF COMPLETION (25)  REPORT AND A 46383  D PROFICENCIES OF CARL PROFICENCIES OF CARL PROFICENCIES OF COMPLETION (25)  D PROFICENCY MALL ST VAL PARAISO, IN 46383  D PROFICENCIES OF CARL PROFICENCIES OF CARL PROFICENCIES OF COMPLETION (25)  D PROFICENCY MALL ST VAL PARAISO, IN 46383  D PROFICENCY MALL ST PROFICENCIES OF CARL PROFICENCIES OF COMPLETION (25)  D PROFICENCY MALL ST PROFICENCE OF CARL PROFICENCE OF COMPLETION (25)  D PROFICENCY MALL ST PROFICENCE OF CARL PROFICENCE OF COMPLETION (25)  TAG  PROFICE AND AL	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIHI D	n.c	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER  (XA) ID SIMMARY STATEMENT OF DEFICIENCIES PREFIX (LACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYEND ROPEMATON)  Also failed to ensure timely attempts were made to notify the family of a resident's death for 1 of 3 discharged residents reviewed in the sample of 14.  (Resident #G)  Findings include:  1. The closed record for Resident #G was reviewed on 11/26/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, renal failure, adult failure to thrive, esophageal reflux, and high blood pressure. The resident was admitted to the facility on 5/16/12 from an inpatient Hospice facility. The resident teaping and discharged to the hospital on 5/9/12.  Review of the resident expired at the facility on 5/16/12 from an inpatient Hospice facility. The resident expired at the facility on 5/19/12.  Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,			155166	1	ING		11/28/	2012
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discharged to the hospital on 5/9/12. The resident was re-admitted to the facility on 5/16/12 from an inpatient Hospice facility. The resident expired at the facility on 5/19/12.  Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,		_						
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5/16/12 from an inpatient Hospice facility. The resident expired at the facility on 5/19/12.  Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. What corrective action(s) will be accomplished for those residents found to have been		I -	_			specified in 483.12(a).		
resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,			•			The facility must also promptly notify	v the	
facility on 5/19/12.  Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,  member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been			-			resident and, if known, the resident	S	
Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,  room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been			-				mily	
Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,  specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. What corrective action(s) will be accomplished for those residents found to have been		facility on 5/19/	12.			_		
information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been						_	nge	
information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been		Review of the re	esident's Admission			-		
no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been		information face	sheet indicated there was					
resident's daughters was listed as a contact /POA (Power of Attorney) for the resident.  The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,  periodically update the address and phone number of the resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been		no Funeral Hom	e listed. One of the				11.	
contact /POA (Power of Attorney) for the resident.  and phone number of the resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been							SS	
resident.  resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those An entry made on 5/19/12 at 3:58 a.m.,  resident's legal representative or interested family member.  What corrective action(s) will be accomplished for those residents found to have been								
The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,  What corrective action(s) will be accomplished for those residents found to have been		`	ower of Attorney) for the				or	
The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m.,  be accomplished for those residents found to have been		resident.						
An entry made on 5/19/12 at 3:58 a.m., residents found to have been							II	
Thi chirty induce on 5/17/12 at 5.50 a.m.,								
indicated the resident's respirations had affected by the deficient							n	
mercured the resident's respirations had		indicated the res	ident's respirations had			•		
ceased at 3:25 a.m., and an order was						practice		
obtained to release the body to the funeral Resident G's family was						Resident G's family was	\$	
home. The resident's daughter (the notified of her passing.			_			<u> </u>	-	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

If continuation sheet Page 4 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00 COMPLETED			
		155166				11/28/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R					
\/\I D\D		DEHABII ITATION CENTED	606 WALL ST VALPARAISO, IN 46383				
	AISO CARE AND P	REHABILITATION CENTER		VALPA	MAISU, IIV 40303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION  (FACH CODDECTIVE ACTION SHOULD BE		(X5	
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLE	
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATI	3
	daughter whose	name was on the face			Resident D no longer		
	sheet) was called	d and a message was left			resides at the facility.		
	to return the call	l. The entry also indicated			How will you identify other		
	Hospice was not	-			residents having the potenti	<sub>al</sub>	
	1				to be affected by the same	··	
	The next entry is	n the Nurses' Notes was			deficient practice and what		
					corrective action will be take	en	
		2 at 6:56 a.m. This entry					
		nily member's phone			· All residents have the		
		ained from Hospice and			potential to be affected by the		
	(names of two fo	emale family members)			alleged deficient practice.		
	were notified an	d several messages were			The information on the		
	left for the daug	hter who was listed on the			resident face sheets will be		
	_	taff were going to			reviewed/verified with the resident's responsibility party.		
		act her. The next entry in			· Upon		
		•			admission/re-admission the IE	т	
		es was made on 5/19/12 at			will review the resident's face		
		entry indicated the			sheet during clinical meeting t	o	
	resident's body v	was released to the funeral			ensure pertinent information is	s	
	home.				available.		
					· IDT will review the		
	When interview	ed on 11/28/12 at 8:35			information on the resident's f		
	a.m., the Directo	or of Nursing indicated			sheet during care plan meetin and update as needed.	ys	
	-	one daughter listed on the			Charts were audited for		
		The Director of Nursing			residents with wounds to ensu		
		· ·			that physician notification		
		d not recall Hospice			occurred for residents with a		
	_	cility upon the resident's			change of condition.		
		ector of Nursing indicated			Nursing Management to		
	there was a dela	y in notifying the			completed skin assessments	on	
	resident's family	7. The Director of			all residents residing at the facility.		
	Nursing indicate	ed it did not appear that			iacility.		
		contacts with Hospice			What measures will be put in	nto	
		to obtain phone number			place or what systemic		
	-	-			changes you will make to		
	of other family f	members until 6:56 a.m.			ensure that the deficient pract	ice	
					does not recur		
						1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155166	A. BUILDING B. WING		11/28/2012
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	l.
NAME OF I	PROVIDER OR SUPPLIEF	R		ALL ST	
<b>VΔΙ ΡΔ</b> Ρ	AISO CARE AND E	REHABILITATION CENTER		RAISO, IN 46383	
				1 1000	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	IAG	Nursing staff will be	DATE
		ecord for Resident #D was		educated on Physician/Family	,
	reviewed on 11/26/12 at 12:40 p.m. The			Notification by the SDC/desig	
	_	oses included, but were		by 12/28/12.	
		enal failure, sleep apnea,		· Nursing staff will be	
		llar disease, diabetes		educated on the Hot Charting	
	· ·	ngestive heart failure. The		Resident Change of Condition policy by the SDC/designee b	
		nitted to the facility in		12/28/12.	'
	7/2012. The res	ident was sent to the		Noncompliance with face	cility
	hospital Emerge	ncy Room on 8/9/12 and		policy and procedure may res	
	was admitted to	the hospital. The resident		in employee re-education and	/or
	was re admitted	to the facility on 8/22/12		disciplinary action up to and including termination.	
	from the hospita	1.		The 24 Hour Report sh	eets
				are audited by the Unit Manag	
	The 8/2012 Nurs	ses' Notes were reviewed.		and/or designee to ensure	
	An entry made o	on 8/6/12 at 5:42 a.m.,		resident change of condition i	S
	<u> </u>	ident was afebrile (not		reported to the physician and family daily.	
		An entry made on 8/6/12		lanny dany.	
	1	icated the resident's		How the corrective action(s) v	vill
	_	coccyx continued as		be monitored to ensure the	
		resident had no signs or		deficient practice will not recu	r,
		Section. The entry also		i.e., what quality assurance program will be put into place	
		ident was afebrile. An		program will be put into place	
				· The Unit Managers will	
	1 -	/6/12 at 7:39 p.m.,		complete a "Change of Condi	
		atment continued to the		and "24 Hour Condition Repo	
	1	x and the resident's		CQI tool daily x 4 weeks, wee 8 weeks and monthly ongoing	•
	_	98.2 (normal). An entry		thereafter for at least 6 month	
		at 6:01 a.m., indicated the		monitor family and physician	
		I had a foul odor and a		notification compliance.	
		sanguineous(red drainage		· Social Services will	"
		nd watery) drainage was		complete a "Care Plan Updati CQI tool weekly x 4 weeks an	_
	observed. The r	next entry was made on		monthly ongoing thereafter fo	
	8/7/12 at 2:45 p.	m. This entry indicated		least 6 months.	
	the the wound v	ac was in place and a		· The "Care Plan Checkl	
	large amount of	serosanguineous ( then		will be utilized during care pla	n

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLE			
		155166	B. WIN			11/28/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\/A  DAD	A100 04 DE AND D	SELLA DIL LEA TIONI OFNITED		606 WA			
		EHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	COMPLETION DATE
TAG				TAG	reviews ongoing. This review		DATE
		age that appears pink due			includes all the information on	the	
		xing in it) drainage was			resident face sheet and will be		
		or remained. An entry			updated as indicated by the ID	Т.	
		at 4:30 p.m., indicated the			<ul> <li>The CQI committee reviews the audits and action</li> </ul>		
		reported the resident had			plans are developed if 95%		
	_	est pain and the resident mumbling words,			compliance is not achieved to		
		r skin was hot to touch.			improve performance, which m	nay	
	•	mperature was 102.2 at			include education, skills validations, performance		
		try made on 8/9/12 at			improvement, and/or disciplina	ıry	
		ited the resident was			action.	, l	
	-	e hospital. An entry					
	•	at 8:16 a.m., indicated					
		admitted to the hospital.					
	the resident was	admitted to the nospital.					
	The facility police	cy titled "Resident					
		ition" was reviewed on					
	_	a.m. The policy was					
		e Director of Nursing					
		e policy was current.					
		lated 8/98 and last					
		The policy indicated the					
		was to notify the					
	_	o the end of the shift					
		nt change in the resident's					
	condition was no	_					
	, , , , , , , , , , , , , , , , , , ,						
	When interviewe	ed on 11/28/12 at 8:35					
		r of Nursing indicated					
		rumentation of the					
		notified of the increased					
		odor of the drainage on					
	8/6/12 and 8/7/1	_					
	5, 5, 12 and 5, 7/1.	<del>_</del> .					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

 ${\small If \ continuation \ sheet \qquad Page \ 7 \ of \ 30}\\$ 

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  IDENTIFICATION NUMBER:  155166	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM	TE SURVEY PLETED 28/2012		
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	This federal tag relates to Complaint IN00112997 and Complaint IN00114283.						
	3.1-5(a)(2) 3.1-5(a)(3)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155166	B. WIN	G		11/28/	2012
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314 SS=D	PRESSURE SOF Based on the con a resident, the factor resident who enterpressure sores do sores unless the condition demons unavoidable; and sores receives ne services to promo infection and previous developing.  Based on observinterview, the factor developing or has turned and reposite residents review the sample of 14 (Residents #K, #Findings include 1. During orient 6:10 p.m., Resided and the head of the resident had inserted into a suneck to maintain The tube was contact the sample of the resident had inserted into a suneck to maintain the tube was contact the sample of the resident had inserted into a suneck to maintain the tube was contact the sample of the resident had inserted into a suneck to maintain the tube was contact the sample of the resident had inserted into a suneck to maintain the tube was contact the sample of the resident had inserted into a suneck to maintain the tube was contact the sample of the sample o	inprehensive assessment of cility must ensure that a sers the facility without been not develop pressure individual's clinical strates that they were a resident having pressure excessary treatment and one healing, prevent went new sores from ation, record review, and cility failed to ensure ents who were at risk for ad pressure ulcers were itioned and pressure swere in place for 3 of 4 and for pressure ulcers in ent.  EM, and #N)  Example 1/25/12 at the ent #K was observed in the matter of the ent was lying on his back the bed was elevated.  The attacheostomy (a tube argical opening in the an airway) tube in place. Innected to a ventilator only oxygen to facilitate	F03	14	F314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who ente the facility without pressure sores do not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice  Resident K, N and M's complain and resident care sheet the been reviewed/updated as indicated and will be followed. Skin Assessment was completed on all three residents and no near the sort of the sort of the service of the sort of the sort of the sort of the service of the sort of the	ers es ne nt tare ave	12/28/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ΓED	
		155166	B. WIN			11/28/2	012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹		606 WA			
VALPAR	AISO CARE AND F	REHABILITATION CENTER			RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	On 11/26/12 at 8	3:00 a.m., the resident was			skin conditions were identified		
	observed in bed	The resident was awake			Resident K is being turn		
	and lying on his	back. There were no			every two hours and is using a pressure-relieving cushion in t		
		r side of the resident.			wheelchair.	.110	
	_	taff members in the room.			Resident N is being turn	ned	
	There were no s	•••••••••••••••••••••••••••••••••••••••			every two hours.		
	On 11/26/12 at 0	9:20 a.m. and 10:15 a.m.,			Resident M is being turn	ned	
		-			every two hours and has a		
		observed sitting in a			pressure-relieving device in th	е	
		e hall. There was no			broad chair.		
	_	g cushion or pad on the					
	seat to the whee	lchair.			How will you identify other		
					residents having the potential	to	
	On 11/26/12 at 1	11:00 a.m., LPN #1, CNA			be affected by the same defici	ent	
	#1. and CNA #2	were observed using a			practice and what corrective		
	· ·	nanical devise to transfer			action will be taken		
	`	ped or a wheelchair) to			Decidents residing in th		
		lent from the wheelchair			<ul> <li>Residents residing in the facility have the potential to be</li> </ul>		
					affected by the alleged deficie		
		en the resident was lifted			practice.		
		chair there was no			<ul> <li>Nursing Management to</li> </ul>	eam	
	_	ure relieving pad on the			completed skin assessments	on	
	seat of the whee	lchair. The resident was			all residents residing at the		
	then turned to hi	s side to remove the sling			facility.		
	used with the Ho	oyer lift. There was a			<ul> <li>Rounds are completed each shift by the charge nurse</li> </ul>	<u>,                                     </u>	
	dressing in place	e to the resident's coccyx			every two hours daily and by	´	
		removed the dressing as			Customer Care Representativ	es	
		been incontinent of stool.			to monitor resident care.		
		ssure ulcer noted to the			Concerns are addressed with	the	
	_	x area. The wound			resident's charge nurse.		
	1				Licensed nurses will be     readurated an following		
	measured approx	-			re-educated on following physician orders and plan of c	are	
	(centimeter) x 2	-			by the DNS/designee by	-ui C	
	reddish/yellow o	eenter.			12/28/12.		
					All staff will be inservice	ed	
	On 11/26/12 at 1	11:55 a.m., the resident			on pressure		
	was observed in	bed. The resident was			reducing/redistribution devices	s by	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155166	B. WING		11/28/2012
NAME OF I	DROVIDED OD GLIDDI IEI		STREE	T ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	PROVIDER OR SUPPLIEF		606 V	VALL ST	
	AISO CARE AND R	EHABILITATION CENTER	VALP	ARAISO, IN 46383	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	·	DATE
	' '	with no pillows to either		the SDC/designee by 12/28/1	۷.
	side of him. The resident was not			What measures will be put int	0
	receiving care fr	om any staff member at		place or what systemic change	
	this time.			you will make to	
				ensure that the deficient pract	tice
	On 11/26/12 at 1	:05 p.m., 3:00 p.m., and		does not recur	
		sident was observed in		The Disaster of Noveline	
	_	nt was lying on his back		<ul> <li>The Director of Nursing Services is responsible to mo</li> </ul>	
		to either side of him. The		for facility compliance.	TINO
		receiving care from any		· Skin assessments are	
				conducted twice weekly durin	g
	staff member at	the above times.		shower/bed bath by a charge	
				nurse to identify any skin	
		0:30 a.m., and 11:10		concerns.	
	a.m., the residen	t was lying on his back		<ul> <li>Unit Managers monitor resident care by making round</li> </ul>	
	with no pillows	to either side of him. The		on their units. Concerns are	us
	resident was not	receiving care from any		addressed with the nursing st	aff
	staff member at	these above times.		as needed.	
				· Rounds are completed	
	On 11/27/12 at 1	1:52 a m two		each shift by the charge nurse	e
		erapy (OT) staff		every two hours daily and by	
	_			Customer Care Representative to monitor resident care.	/es
		bserved transferring the		Concerns are addressed with	the
		s bed into the wheelchair.		resident's charge nurse.	
		ember placed a folded		· Observations will be	
		on the seat of the		documented on the "Nursing	
	wheelchair. The	re was no cushion or		Rounds Checklist" ongoing.	The
	pressure relievin	g device in place on the		DNS/designee reviews the	ala ilu
	seat of the wheel	chair when he was		"Nursing Rounds Checklists" Monday – Friday. The Weeke	· •
	transferred into t	he wheelchair.		Nursing Manager checks ther	
				Saturday and Sunday for	
	On 11/27/12 at 1	2:40 p.m. and 1:00 p.m.,		compliance.	
		observed sitting in the		Licensed nurses will be	)
		s room. There was no		re-educated on following	
				physician orders and plan of o	care
	cusnion noted or	the seat of the chair.		by the DNS/designee by 12/28/12.	
				12/20/12.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155166	B. WIN			11/28/2012
			P		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8		606 WA		
VALPAR	AISO CARE AND F	REHABILITATION CENTER			RAISO, IN 46383	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		1:05 p.m., two OT staff			All staff will be inservice	d
	members were observed transferring the				on pressure reducing/redistribution devices	s by
resident from the wheelchair into his bed.				the SDC/designee by 12/28/12		
	The white sheet	was present on the seat of			1 110 02 07 000 191100 27 127207 12	-
	the chair. There	was no cushion or				
	pressure relievin	g device observed on the			How the corrective action(s) w	ill
	seat of the chair.	~			be monitored to ensure the	
					deficient practice will not recur i.e., what quality assurance	,
	The record for R	Resident #K was reviewed			program will be put into place	
					program nim 20 pat into place	
	on 11/26/12 at 11:00 a.m. The resident was admitted to the facility on 11/16/12.				· Nurses will document	
					observations on the "Nursing	
		agnoses included, but			Rounds Checklist" each shift	
		to, tracheostomy, high			ongoing. The DNS/designee	
	•	acute respiratory failure,			reviews the "Nursing Rounds Checklists" daily Monday –	
	and malnutrition	l.			Friday. The Weekend Nursing	
					Manager checks them on	
	Review of the 1	1/20/12 Pressure Wound			Saturday and Sunday for	
	Skin Evaluation	Report indicated the			compliance.	
	resident had an u	ınstageable pressure			<ul> <li>The Customer Care Representatives will complete</li> </ul>	tho
	wound to the co	ccyx. The measurements			"Accommodation of Needs" Co	
		s 2.0 cm x 1.9 cm.			tool will be utilized weekly x 4,	
		1/16/12 admission			then monthly ongoing thereaft	
		isk Assessment indicated			no less than 6 months.	
		at risk for pressure ulcers			Data will be submitted to the COL Committee for review.	0
		sed mobility and a history			the CQI Committee for review and follow up. If a 95%	
		-			compliance is not achieved an	
	of pressure ulcer	.5.			action plan will be developed.	
	Davious of the 1	1/16/12 admission			Noncompliance with factors	ility
					procedures may result in	
	-	s indicated there was an			disciplinary action.	
		the coccyx wound with				
		pply Santyl (a medicated				
		ride a wound) and a				
	fluffed gauze an	d cover the area daily and				
	as needed.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155166	B. WIN	G		11/28/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
				606 WA		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPAI	RAISO, IN 46383	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	D : 64	.1				
		sident's temporary				
	admission care plans indicated there was					
	_	noted the resident had				
	-	tegrity. The temporary				
	-	tiated on 11/16/12. Care				
	. ^	is included for staff to				
		on the resident every 2				
		ded. Another intervention				
	indicated a pressure					
	reducing/relieving/redistribution device to					
	the chair was to	be utilized.				
		1 11/20/12 0.07				
		ed on 11/28/12 at 9:35				
		r of Nursing indicated the				
		e turned and repositioned				
	^	lieving pad should have				
	been in place as	per the resident's plan of				
	care.					
		ation tour on 11/25/12 at				
		ent #N was observed in				
		nt's eyes were closed and				
		and when staff entered the				
		ent was lying on her back				
		s turned to the left side.				
	The resident's ar	ms were lying straight				
		side of her. There were				
	pillows under ea	ch of the resident's arms				
	and hands. Ther	e were no other pillows				
	to either side of t	the bed. The resident was				
	not receiving car	e from staff at this time.				
	The head of the	resident's bed was				
	elevated. The re	sident had a				

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Event ID: XCQP11

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166			LDING	NSTRUCTION  00	(X3) DATE : COMPL 11/28/	ETED			
	PROVIDER OR SUPPLIER	EEHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
		oe in place and the tube o a ventilator at the							
	observed in bed The resident was pillows remained There were no of of the bed. The	8:10 a.m., the resident was with her eyes closed. s on her back and the d under each of her arms. ther pillows on either side resident's eyes were dent was not receiving t this time.							
	observed in bed The resident was remained under were no other pi bed. The residen	2:10 a.m., the resident was with her eyes closed. It is on her back and pillows each of her arms. There allows on either side of the int's eyes were closed. It is not receiving care from							
	was observed in The resident was pillows remained There were no of of the bed. The	0:15 a.m., the resident bed with her eyes closed. s on her back and the d under each of her arms. ther pillows on either side resident's eyes were dent was not receiving t this time.							
	was observed in	1:10 a.m., the resident bed with her eyes closed. s on her back and the							

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Event ID: XCQP11

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		A. BUILD		NSTRUCTION  00	(X3) DATE S COMPL 11/28/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		606 WAI VALPAR	LL ST RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	pillows remained There were no or of the bed. The closed. The resi care from staff a on 11/26/12 at 1 was observed in The resident was pillows remained There were no or of the bed. The closed. LPN #2 time and administresident through On 11/26/12 at 1 was observed in The resident was pillows remained There were no or of the bed. The closed. The resident was pillows remained There were no or of the bed. The closed. The resident was observed in The resident was pillows remained There were no or of the bed. The resident was pillows remained There were no or of the bed. The	d under each of her arms. ther pillows on either side resident's eyes were dent was not receiving t this time.  2:00 p.m., the resident bed with her eyes closed. s on her back and the d under each of her arms. ther pillows on either side resident's eyes were entered the room at this stered medications to the her feeding tube.  :02 p.m., the resident bed with her eyes closed. s on her back and the d under each of her arms. ther pillows on either side resident's eyes were dent was not receiving t this time.  ::30 p.m., the resident bed with her eyes closed. s on her back and the d under each of her arms. ther pillows on either side resident's eyes were dent was not receiving t this time.		TAG	DEFICIENCY)		DATE
	closed. The resi care from staff a	dent was not receiving this time.					

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Event ID: XCQP11

Facility ID: 000083

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155166	B. WING	·		11/28/	2012
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				606 WA			
VALPAR	AISO CARE AND F	REHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		lesident #N was reviewed					
		:30 p.m. The resident's					
	diagnoses included, but were not limited						
	to, respirator dependence, anemia, morbid						
	obesity, and convulsions.						
	Review of the 11/2012 Physician Order						
		ated there was an order					
	written on 10/30	* * *					
		eam to the groin and					
	buttock areas ev	ery shift.					
	D : 0.1 1	1/00/10 D					
		1/20/12 Pressure Wound					
		Reports indicated the					
		age II ulcer to the right					
		ther stage II (an ulcer with					
		loss of dermis presenting					
		n ulcer with a red pink					
	· ·	to the right superior					
	buttock area.						
		irrent care plans were					
		e was a care plan					
		sident was admitted to the					
	I -	a to her left buttock, right					
		nt superior buttock and					
		dependent on staff for					
	1	he care plan was initiated					
	on 11/6/12. Car	e plan interventions					
	included for the	resident to be turned and					
	repositioned rou	tinely. Another care plan					
	was initiated on	11/7/12. This care plan					
	indicated the res	ident was at risk for					
	further skin brea	kdown related to					
	l						l

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Event ID: XCQP11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155166	B. WIN	IG		11/28/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIET	•		606 WA			
VALPAR	AISO CARE AND R	REHABILITATION CENTER		VALPAF	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ty, incontinence, and a					
	diagnosis of diabetes. Care plan						
	interventions inc	cluded for staff to turn and					
	reposition the re	sident at least every two					
	hours						
	When interviewe	ed on 11/28/12 at 9:35					
		or of Nursing indicated the					
		be turned and repositioned					
		as per her plan of care.					
	every two nours	as per ner plan or care.					
	3 During orient	tation tour on 11/25/12 at					
	_	ent #M was observed in					
		nt was lying on her back.					
		s not receiving any care					
	from staff at this	time.					
	On 11/25/12 at 6	).15 41					
		3:15 p.m., the resident					
		bed. The resident was					
		lent was not receiving					
	care from staff a	t this time.					
		7:45 a.m., the resident was					
		The resident was lying					
	on her back and	was not receiving care					
	from staff at this	time.					
	On 11/26/12 at 8	3:50 a.m., the resident was					
	observed in bed.	The resident was lying					
		was not receiving care					
	from staff at this	•					
	On 11/26/12 at 0	9:15 a.m., the resident was					
		The resident was lying					
	ooserved in oed.	The resident was lying					

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Event ID: XCQP11

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	DINC	00	COMPL	ETED
		155166	A. BUI. B. WIN	LDING G		11/28/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹		606 WA			
VALPARA	AISO CARE AND R	REHABILITATION CENTER			RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on her back and	was not receiving care					
	from staff at this	s time.					
	On 11/26/12 at 1	10:25 a.m., the resident					
	was observed in bed. The resident was						
		k and was not receiving					
	care from staff a	_					
	isi c ii ciii ciiii u	·					
	On 11/26/12 at 1	11:15 a.m. the resident					
	On 11/26/12 at 11:15 a.m., the resident						
	was observed in bed. The resident was						
	lying on her back and was not receiving care from staff at this time.						
	care from staff a	ti this time.					
	On 11/26/12 at 1	12:55 p.m., the resident					
		tting in a Broda chair in					
		•					
	the unit Dining I	XOOIII.					
	On 11/26/12 at 1	1:55 p.m., the resident					
		tting in the Broda chair in					
		#2 and LPN #3 entered					
		om and transferred the					
		e chair into her bed using					
		ice. When the resident					
	_	the Broda chair there was					
		ure relieving cushion on					
	the seat of the ch	lali.					
	The record for R	Resident #M was reviewed					
		:35 p.m. The resident's					
		led, but were not limited					
	-	rosis, iron deficiency					
		•					
	anemia, dementi	a, and osteopath.					
	Review of the 1	1/2012 Physician Order					

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Event ID: XCQP11

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/28/2012			
	PROVIDER OR SUPPLIER AISO CARE AND R	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	cleanse the cocc saline, apply Sol wounds), a fluffe	ted there was an order to yx wound with normal oist (an ointment to treat ed gauze, and cover the sing once a day and as						
	Evaluation Report had a Stage IV (a thickness tissue tendon, or muscl	essure Wound Skin ort indicated the resident a wound with full loss with exposed bone, e) wound to the coccyx. sured 0.7 cm x 0.6 cm x						
	Risk Assessmen was at risk for sk resident has deci diagnosis of mul	1/20/12 Pressure Sore t indicated the resident kin breakdown as the reased mobility, a tiple sclerosis, and a re ulcers and a recent						
	reviewed. A car 1/13/12 indicated areas to the cocc Care plan interveto turn and repostroutinely. The cwith a goal date plan initiated on resident was at r	e plan initiated on d the resident had open yx, heel, and knee area. entions included for staff sition the resident are plan was last updated of 12/4/12. Another care 4/12/11 indicated the isk for further skin ed to impaired skin						

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Event ID: XCQP11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		A. BUILDING  B. WING	COMPLETED  11/28/2012				
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG	BE COMPLETION				
	integrity, requiring total care for bed mobility and having contractures. Care plan interventions included for the resident to have a pressure reducing cushion to the Broda chair.  When interviewed on 11/28/12 at 9:35 a.m., the Director of Nursing indicated the resident's plan of care for repositioning and the use of a pressure reducing						
	cushion to the Broda chair should have been followed.  This federal tag relates to Complaint						
	IN00114283. 3.1-40(a)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		A. BUILE	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/28/2012		
VALPAR	T	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0323 SS=D	The facility must environment ren hazards as is por receives adequate supervimplementing in elopement when transferred off a The facility also employees were implemented after residents review the sample of 1-had the potential residents residing (Resident #B)  Findings including orientate 7;15 p.m., Residual to residing on the was a secured with the record for 1 on 11/26/12 at 2 diagnoses inclute, Alzheimer's	ensure that the resident pains as free of accident sains as free of accident saible; and each resident ste supervision and test to prevent accidents. Wation, record review, and accility failed to provide vision related to interventions to prevent in a resident was a secured nursing unit. To failed to ensure all the inserviced on procedures iter an elopement for 1 of 1 and for elopement risk in the interventions to failed to affect 26 of 26 and on the secured unit.  This deficient practice all to affect 26 of 26 and on the secured unit.  The intervention is prevent accident practice and the secured unit.	F032	3	F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/DEVICES The facility must ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevaccidents This tag is being disputed.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice  A new elopement risk assessment was completed for Resident B and she was move into the cottage.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take  Residents residing in the facility have the potential to be affected by the alleged deficient practice.  The facility implemented	as  vent  r ed  n e e e n n	12/28/2012

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Event ID: XCQP11

Facility ID: 000083

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLE	ETED
		155166	B. WIN			11/28/2	2012
		ı	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	3		606 WA			
VALPAR	AISO CARE AND F	REHABILITATION CENTER			RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident had bee	n moved off of the			plan for residents being		
	Cottage unit on	11/8/12 to another unit in			discharged from the cottage to		
	the facility that was not a secured unit.				the general facility. All staff w	as	
		was not a secured unit.			inserviced on the protocol by		
	Davious of the O	/11/12 "Elanament Digle			11/28/12 and monthly ongoing the all staff meeting.	y at	
	Review of the 9/11/12 "Elopement Risk Assessment" indicated the resident was				What measures will be put in	nto	
					place or what systemic		
	-	nobile with either			changes you will make to		
	ambulation or in	a wheelchair, the			ensure that the deficient		
	resident often re	quested to go home and			practice does not recur		
	or is searching for	or home, and the resident					
experiences increased confusion at certain					<ul> <li>The facility implemented</li> </ul>	da	
	_	. The above indicated the			plan for residents being		
	resident was an				discharged from the cottage to		
	Testuent was an	cropement risk.			the general facility. All staff w inserviced on the protocol by	as	
					11/28/12 and monthly ongoing	t at	
		1/8/12 Facility Incident			the all staff meeting.		
	indicated the res	ident was brought into			The Director of Nursing		
	the facility by vi	sitor at approximately			Services is responsible to mor		
	8:20 p.m. The r	esident did not leave the			for facility compliance.		
	facility property	. The resident had no			· Elopement Risk		
		nd no overt signs of			Assessments will be complete	ed	
	-	derguard was applied			for any residents being	_	
		•			discharged from the cottage to the general facility and the	ر	
	_	t's return into the			protocol will be followed.		
	building.				· The Unit		
					Manager/designee will ensure		
		de on 11/9/12 indicated			that the protocol is followed ar	nd	
	the team met to	review the resident's exit			the orders are in place prior to		
	seeking and the	resident was to be moved			resident being discharged fror	n	
		secured unit at this time.			the cottage.		
	   When interview	ed on 11/26/12 at 3:30			How the corrective action(s)		
	When interviewed on 11/26/12 at 3:30 p.m., the Assistant Director of Nursing indicated the DON had put a new plan in				will be monitored to ensure t	he	
					deficient practice will not rec		
					i.e., what quality assurance	,	
place. The Assistant Director of Nursing				program will be put into place	e l		
	provided the wri	itten plan at this time.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155166	B. WIN	G		11/28/	2012
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				606 WA			
VALPAR	AISO CARE AND R	REHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	· ·		DATE
TAG	The plan was titl being discharged facility." The portage of the general facility of the physician orders of the general facility of the physician orders of the general facility of the physician orders of the physician ord	rguard. Check least every shift for orative to check illy for function. ute where-a-bout checks for the first 24 hours. ute where-a-bout checks for the following 24 here-a -bout checks for s. ssment will be completed 72 hour where-a-bout bleted to determine if use is yet indicated."  ed on 11/27/12 at 8:05 or of Nursing indicated		TAG	Observations will be documented on the "Missing Resident/Elopement" CQI tool weekly x 4, then monthly thereafter for at least 6 months.  Data will be submitted to the CQI Committee for review and follow up.  If a 95% compliance is not achieved an action plan will I developed.  Noncompliance with facility procedures may resu in disciplinary action.	S S. CO	DATE
	she implemented the above protocol after Resident #B had been found outside of						
	the facility on 11/8/12. The Director of						
	I						
Nursing indicated when she was informed							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		NSTRUCTION 00	(X3) DATE S	ETED		
		155166	B. WING			11/28/	2012	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383					
							715)	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	PRI	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)		DATE	
		eing found outside that						
		ke with the Charge Nurse						
	and informed her that no residents are to							
		eured unit until she						
		morning. The Director of						
		d she inserviced the IDT						
		above protocol as they						
	_	es that are involved in the						
		e any residents off the						
	secured unit and	-						
	•	sure the Physician order						
	were written as a	above and transcribed						
	onto the Medicat	tion Administration						
	Record or the Tr	eatment Administration						
	Record. The Dir	rector of Nursing						
	indicated other s	taff were not inserviced						
	as the orders wo	uld be written for staff to						
	follow.							
	When interviewe	ed on 11/26/12 at 3:20						
		e Unit Manager indicated						
	the resident had	resided on the secured						
	unit for several r	nonths prior to her being						
	moved off the ur	nit on 11/8/12. The						
	Cottage Unit Ma	nager indicated the						
	resident was mo	ved in the morning of						
	11/8/12 and was	found outside of the						
	facility that even	ing. The Cottage Unit						
	Manager indicate	ed there was not a policy						
	related to the train	nsfer of resident's off the						
	secured unit.							
	When interviewe	ed again on 11/26/12 at						
	4:00 p.m., the Co	ottage Unit Manager						

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Event ID: XCQP11

Facility ID: 000083

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		ĺ	LDING	NSTRUCTION  00	(X3) DATE COMPI 11/28	LETED	
NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	attempting to prounit and the residexit seeking. The indicated in the properties of	ed on 11/26/12 at 4:25 Administrator indicated of the resident being the facility on 11/8/12. Or indicated staff time. The Administrator stocol was for residents to hard applied when they ff the secured unit. The dicated the resident did erguard placed on before red off the secured unit as he Administrator indicated dursing put a plan into the resident was was  ed on 11/27/12 at 9:30 E Unit Manager indicated for all residents to have a polied prior to being mit and this was not done					

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Event ID: XCQP11

Facility ID: 000083

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/28/2012	
	PROVIDER OR SUPPLIE AISO CARE AND F	REHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(2)				

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Event ID: XCQP11

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
155166		B. WING			11/28/2012		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
VALPARAISO CARE AND REHABILITATION CENTER				606 WALL ST VALPARAISO, IN 46383			
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		PLETE/ACCURATE/ACCE					
	SSIBLE	and the second second					
	-	maintain clinical records on					
		accordance with accepted dards and practices that					
		curately documented;					
	•	e; and systematically					
	organized.	.,					
	The clinical recor	d must contain sufficient					
		ntify the resident; a record					
		assessments; the plan of					
		s provided; the results of					
		n screening conducted by					
	the State; and pro	_	F05	1.4			12/20/2012
		review and interview, the	F05	14	F514 Clinical Records The facility must maintain clini	cal	12/28/2012
	_	ensure clinical records			records on each resident in	cai	
	were complete a	·			accordance with accepted		
	documented rela	ted to medications not			professional standards and		
	signed out on the	e Medication			practices that are complete;		
	Administration I	Records and lack of			accurately documented; readil		
	documentation o	f funeral home			accessible; and systematically organized.		
	arrangements for	r 1 of 3 closed records			J. 34111241		
	reviewed for con	nplete and accurate			The clinical record must conta	in	
		n the sample of 14.			sufficient information to identify	y	
	(Resident #G)	· · · · · · · · · · · · · · · · · · ·			the resident; a record of the		
	(Resident #G)				resident's assessments; the pl		
	Finding to 1 1				of care and services provided;	tne	
	Findings include	); 			results of any preadmission screening conducted by the		
					State; and progress notes.		
	The closed recor	rd for Resident #G was			Cate, and progress notes.		
	reviewed on 11/2	26/12 at 11:30 a.m. The			What corrective action(s) wil	I	
	resident's diagno	ses included, but were			be accomplished for those		
	_	nal failure, adult failure			residents found to have beer	1	
	-	geal reflux, and high			affected by the deficient		
					practice		
	bibba pressure.	The resident was					

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Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
155166		155166	A. BUILDING B. WING		11/28/2012
		L		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				ALL ST	
VALPARAISO CARE AND REHABILITATION CENTER				ARAISO, IN 46383	
				1000, 111 40000	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		facility on 4/7/12 and		There is no corrective action for Resident G as she	20
	discharged to the	e hospital on 5/9/12. The		longer resides at the facility.	10
	resident was re-	admitted to the facility on		Resident G's family was notifi	ed
	5/16/12 from an	inpatient Hospice		and she was released to the	
	facility. The re	sident expired at the		funeral home the family chose	e.
	facility on 5/19/			How will you identify other	
				residents having the potenti	al
	Davious of the re	esident's Admission		to be affected by the same	
				deficient practice and what	
		e sheet indicated there was		corrective action will be take	en
		e listed. One of the		· Residents residing in the	10
	_	ters was listed as a		facility have the potential to be	
	contact /POA (P	ower of Attorney) for the		affected by the alleged deficie	
	resident.			practice.	
				· Licensed nurses will be	;
	Review of the 5	/2012 Nurses' Notes		re-educated on physician's or	
	indicated an ent	ry was made on 5/19/12 at		and MAR/TAR documentation	
	2:25 a.m., documented the resident was			requirements and use of PRN	I
	1	out, and her respirations		medications by the DNS/design by 12/28/12.	griee
		_		• The information on the	
		he entry also indicated the		resident face sheets will be	
	_	en Morphine (a pain		reviewed/verified with the	
	· /	Ativan (a medication for		resident's responsibility party.	
	anxiety). An er	ntry made on 5/19/12 at		· Upon	_
	3:58 a.m., indica	ated the resident's		admission/re-admission the II	)
	respirations had	ceased at 3:25 a.m., and		will review the resident's face sheet during clinical meeting	to
	an order was ob	tained to release the body		ensure pertinent information i	
		ome. The entry also		available.	
		sage was left for the		· IDT will review the	
		to call the facility. An		information on the resident's t	I
	1	/19/12 at 6:56 a.m.,		sheet during care plan meetir	gs
	I -			and update as needed.	
		l messages were left for		What measures will be put int	_
	the daughter who was the resident's POA			place or what systemic change	
		nome was to be notified		you will make to ensure that t	
	when the family	was notified. The next		deficient practice does not red	I
	entry in the Nur	ses' Notes was made on			

STATEMENT OF DEFICIENCIES X1) PI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155166	A. BUIL B. WING			11/28/	2012
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
VALPARAISO CARE AND REHABILITATION CENTER				606 WA			
VALPAR	AISO CARE AND P	REHABILITATION CENTER		VALPARAISO, IN 46383			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE
	5/19/12 at 9:02 a	n.m. This entry indicated			· The IDT reviews the		
	the funeral home	e was at the facility and			physician orders at the clinica		
	the resident's bo	dy was released. There			meeting. The Unit Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed		
		ntation of family member					
		-					
	_	for the funeral home					
	choice.				(Monday-Friday).		
					DNS/designee will assign	na	
	Review of the 5/	2012 Medication			license nurse on weekends to		
	Administration I	Record indicated the			review the medication		
	Morphine and A	tivan medications were			administration records to		
	•	s given on 5/19/12 at 2:25			· ensure medications have		
	<u> </u>	5 given on 3/19/12 at 2.23			been administered per physic	an	
	a.m.				orders.	_ 4"	
					The "Care Plan Checkli     will be utilized during care plan		
	The facility poli	cy titled "Medication			reviews ongoing. This review		
	Administration"	was reviewed on			includes all the information on		
	11/28/12 at 10:3	0 a.m. The policy was			resident face sheet including		
		Director of Nursing.			funeral home of choice and wi	II	
		te on the policy. The			be updated as indicated by the	е	
		ing indicated the policy			IDT.		
		e policy indicated Nurses			How the corrective action(s) w	/ill	
	_	edications were to sign			be monitored to ensure the		
	out the medication	ons given on the			deficient practice will not recui	Γ,	
	Medication Reco	ord.			i.e., what quality assurance		
	177047047071				program will be put into place		
	When interview	ed on 11/28/12 at 10:30			The Unit Managers will		
		or of Nursing indicated the			complete the "MAR/TAR" CQI		
	*	•			tool will be utilized weekly x 4,		
		Morphine and Ativan			then monthly ongoing thereaft		
	should have been	_			for at least 6 months.		
	Medication Adn	ninistration Record at the			· Social Services will		
	time they were g	given.			complete a "Care Plan Updati		
					CQI tool weekly x 4 weeks an		
	This federal tag	relates to Complaint			monthly ongoing thereafter for least 6 months.	al	
	IN00112997.				Data will be submitted t	0	
	11100112///				the CQI Committee for review		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  155166	A. BUILDING  B. WING	00	COMPLETED 11/28/2012
VALPAR	PROVIDER OR SUPPLIER  AISO CARE AND REHABILITATION CENTER	STREET A 606 WA VALPAI	RAISO, IN 46383	(V5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	3.1-50(a)(1) 3.1-50(a)(2)	TAG	and follow up.  If a 95% compliance is not achieved an action plan will be developed.  Noncompliance with far procedures may result in re-education and or disciplina action.	pe acility

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XCQP11

Facility ID: 000083

If continuation sheet

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